

DEBBY RANSOM, R.N., R.H.I.T – Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888 E-mail: §b@dhw.idaho.gov

June 23, 2010

RICHARD M. ARMSTRONG - Director

FerrenWeeks, Administrator Yellowstone Group Home #4 (Fox Hollow) 560 West Sunnyside Idaho Falls, Idaho 83401

RE: Yellowstone Group Home #4 (Hollow), Provider #13G066

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Yellowstone Group Home #4 Hollow, on June 15, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- 2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

FerrenWeeks, Administrator June 23, 2010 Page 2 of 2

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 6, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY

Health Facility Surveyor

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Fire Life Safety & Construction Program

TB/lj

Enclosure

Printed: 06/22/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING			(X3) DATE SURVEY COMPLETED				
							06/15/2010			
	ROVIDER OR SUPPLIER	OME #4 /EOV DOLL		RESS, CITY, S	TATE, ZIP CODE					
TELLOV	STONE GROUP H	DIVIE #4 (FOX NOLI		FALLS, ID						
(X4) ID		ATEMENT OF DEFICIENCE		ID !		S PLAN OF CORREC		(X5) COMPLETION		
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K 000	INITIAL COMMENT	rs		K 000	71	71	, 			
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:	facility during the ar conducted on June surveyed under the Edition, Chapter 33	encies were cited at nual Fire/Life Safety 15, 2010. The facilit LIFE SAFETY COD , Existing Residentia cies, adopted 11 Mat 42 CFR 483.470.	v survey ty was E, 2000 I Board	÷				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	The annual fire/life by:	safety survey was co	onducted					, 14, 4,		
	Taylor Barkley Health Facility Survi Facility Fire Safety a									
K0148	483.470(j)(1)(i) LIFE STANDARD	E SAFETY CODE		K0148				:		
		s are adopted by the ard and care occupa		Ì				;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;		
	Based on record rev	ot met as evidenced view it was determing ave a smoking policy	ed that							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

facility. The facility had a census of five clients on

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Pege 1 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 06/22/2010

FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G 02		(X3) DATE SURVEY COMPLETED		
		13G066		B. WING_		06/	06/15/2010	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		 !	
YELLOV	VSTONE GROUP H	OME #4 (FOX HOLI		DLLOW DR				
			IDAHO	FALLS, ID	83404			
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K0148	Continued From pa	age 1		K0148			, , ,	
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	The findings include	e:						
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160 4 7 4	104 1540 1540		1				;	
K0154	483,470(j)(1)(i) LIFE STANDARD	E SAFETY CODE		K0154			I and service assessment as	
							- Marian	
	out of service for me period, the authority notified, and the bui approved fire watch parties left unproted	utomatic sprinkler sy ore than 4 hours in a having jurisdiction s ilding shall be evacua system be provided ted by the shutdown s been returned to se	24-hour hall be ated or an for all until the					
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		view it was determine ave a fire watch polic						
	facility in the event of	of a sprinkler system ensus of five clients o	failure.					
	The findings include	: :		Ì			<u>.</u>	
	plans on June 15, 29 determined that the	w of the facility's eme 010 at 10:25 AM, it w facility did not have a acility. Findings were	ras a fire					

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 2 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Yellowstone Group Homes

Printed: 06/22/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED	
13G066			B. WING 06/			15/2010		
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 (FOX HOLL 370 HOLLOW DRIVE IDAHO FALLS, ID 83404								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED B' LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE	
K0154	Manager. This defi-	age 2 ne Facility Maintenan ciency affected all sta he day of the survey.	aff and	K0154				
	service for more that the authority having and the building shapproved fire watch shall be provunprotected by the system has been retained that the facility did not have facility and a confit of the survey. The findings include During record review plans on June 15, 2 determined that the watch policy in the fithe Surveyor and the Manager. This deficitions approved the surveyor and the Manager. This deficitions approved the surveyor and the Manager. This deficit watch policy in the fithe Surveyor and the surveyor and the Manager. This deficit watch policy in the fithe Surveyor and the surveyor	ire alarm system is or an 4 hours in a 24-ho i jurisdiction shall be all be evacuated or al ided for all parties lef shutdown until the fine turned to service. It met as evidenced by view it was determine ave a fire watch police of a fire alarm system	our period, notified, noti	K0155				

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 3 of 3

Yellowstone Group Homes

PRINTED: 06/22/2010 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 06/15/2010 13G066 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 370 HOLLOW DRIVE YELLOWSTONE GROUP HOME #4 (FOX HOLLOW) IDAHO FALLS, ID 83404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN DF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 16.03.11 Inital Comments M 000 M 000 The facility is a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13 D system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on June 15, 2010. The facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, " Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life Safety Code, Impractical Evacuation Capability in accordance with IDAPA 16.03.11. The annual fire/life safety survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction MM309 16.03.11.110 Fire and Life Safety Standards MM309 Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. K0154 Fire watch policy for sprinkler system failure. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE STATE FORM

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PRINTED: 06/22/2010 FORM APPROVED

Bureau of Facility Standards									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		R/CLIA 1BER:	A. BUILDING	CONSTRUCTION 02	(X3) DATE SU COMPLET				
13G066			B. WING 06/15/2010						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
YELLOWSTONE GROUP HOME #4 (FOX HOLLOW) 370 HOLLOW DRIVE IDAHO FALLS, ID 83404									
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2. K0155 Fire watch failure. 3. K0148 Smoking	h policy for fire alarm	system							
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Fire Life Safety Plan of Correction Home #4 Foxhollow #13G066 7/6/2010

K0148

All staff will be in serviced on the policy and a copy will be placed in the home's Work Safety Manual. All staff will also be in serviced on the Work Safety Manual and its location in the home. The policy was located already in our Employee Orientation Packet and our Employee Handbook. To assure the policy is in our manuals it will be incorporated into our annual OSHA Annual Inspection Calandar.

Responsible person will be the Home Administrator to be completed by July 30th 2010

K0154

A fire watch policy has been developed and implemented in the event either system becomes inoperable as stated in life safety standards K0154 and K0155. Responsible party is Ferren Weeks, Regional Administrator and will be completed by 7/10/2010.

Currently when either system is in trouble or there is false alarm the maintenance person is to be notified immediately and if the maintenance person is unreachable then the Regional Administrator will be contacted. The maintenance person is to then:

- Notify the Regional Administrator. (If maintenance person is unavailable the Regional Administrator will designate an employee to:)
- 2. Go to the location or direct the home staff how to correct the problem.
- 3. If unable to correct, our contract services will be contacted to correct the problem.
- 4. If unable to correct with in 4 hours then the fire watch policy will be implemented.

A copy of the Fire Watch Policies and Procedures will be provided to the Bureau. All staff will be in serviced on the policy and a copy will be placed in each homes Work Safety Manual. All staff will also be in serviced on the Work Safety Manual, its location in each home, and added to our Employee Orientation Packet.

Responsible person will be each Home Administrator to be completed by July 30th 2010.

K0155- Please refer to K0 154

MM309(1 & 2) Please refer to K0154

MM309 (#3) Please refer to K0148

firen J. Wulss Regional admin Halio